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ABSTRACT

The mental health care delivery system is undergoing a metamorphosis of unprecedented proportion as managed care covers more and more patients. This dramatic change has its critics (many mental health professionals) and its enthusiastics (the managed behavioral health care companies). Some of these issues are presented in this paper. There is widespread concern that managed care may be applied to the treatment of the mentally ill and substance abusers in ways that neglect the special needs of these populations. The topics covered here include the downside of managed care for patients, such as excessive cost-cutting resulting in compromised treatment, and potential conflicts of interest in health care delivery. Some of the negative consequences of managed care for providers are also detailed, including the perceived interference with the doctor-patient relationship engendered by managed care. Other issues covered are concerns over excessive administrative overhead and profit-taking, complaints that individual providers have about managed care, examples of the frustrations expressed by an insider in managed care provider, attrition among managed care providers, the need for better research, and some of the protests and reforms being advocated. Specific concerns include issues of privacy, utilization review, a lack of efficiency, the "gatekeeper" function, questions of accountability, and concerns for the quality of treatment. (Contains 26 references.) (EMK)

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Educating Future Therapists about the Controversy Surrounding Managed Behavioral Healthcare

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Criticisms of Managed Behavioral Healthcare (MBHC)

The mental health delivery system is undergoing a metamorphosis of unprecedented proportion, and not everyone is finding the adjustment easy. This dramatic change has its critics (many mental health professionals) and its enthusiasts (the managed behavioral health care companies). Tomorrow's psychotherapists need to understand the controversy in a balanced way, in order to help them develop strategies for accommodating the professional demands they will face.

Critics of managed care have coined a variety of disparaging names for managed care that capture their distaste, including mangled care, mismanaged care, managed neglect, discounted care, Shop-a-Doc, Gag Me With a Spoon Care, and managed chaos. Mental health professionals are increasingly disenchanted with managed care. What was once proclaimed to be innovative quality care has evolved into "profits through cost containment". The needs and concerns of patients and health care professionals are considered last, if at all. The perceived abuses of many managed care companies include the compromise of confidentiality, pressures to homogenize treatment, the inefficiency of management from a distance, and profit margins well in excess of most businesses.

Objections emphasize the perception that managed care companies extract obscene profits from the health care system by denying needed care, unnecessarily threaten the autonomy of providers, and compromise patients' rights to informed consent and to confidentiality, through gag

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clauses, incentive systems, and close utilization review procedures.

The Downside for Patients
Excessive Cost-cutting Compromises Treatment

Karon (1995) decries the cost cutting methods that some feel have purged health care of its traditional commitment to quality. These have included neglect of prevention programs in high-risk populations, excessive reliance on medication rather than psychotherapy, substituting less expensive personnel as care givers, and restricting the scope of behavioral health services actually provided. Karon maintains that in some cases, quotas were established that dictated how many patients must be processed per hour.

Many believe that managed care companies wish they didn't have to make provisions for psychotherapy at all, and that they only do so because excluding it would interfere with recruitment. Critics maintain that the aim of managed care concerns is to provide as little psychological care as possible while seemingly providing adequate mental health care. According to Iglehart (1996), HMOs currently spend only 3% to 5% of their treatment budget on mental health, which many see as inadequate.

There is widespread concern that managed care may be applied to the treatment of the mentally ill and substance abusers in ways that neglect the special needs of these populations. For example, there may be a failure to identify enrollees with severe mental illnesses, and therefore these individuals may receive less treatment. With capitated systems, financial incentives favor neglecting the care needs of chronically mentally ill patients. So long as failure to provide care does not result in blatant evidence of negligence (death or serious injury to self or others) which could form the basis for costly litigation, many capitated organizations will be financially rewarded for looking the other way and ignoring the misery and isolation of their severely mentally ill enrollees. Alternatively, organizations that respond conscientiously to the sprawling needs of these draining patients, will be at serious financial risk. In competition with service-denying companies, their contracts will unlikely cover anything like the true costs of providing the necessary care required by the SMI. The "good guys" will lose and the callous will win, unless appropriate safeguards are put into place.

Increasingly, policies' mental health benefits cover only crisis intervention and stabilization, not treatment. A subscriber might have coverage for up to 20 sessions of outpatient therapy and 20 days of inpatient treatment, but this only covers crisis intervention and stabilization. Some providers have expressed concerns that such policies will create a serious bind when they conduct evaluations on

individuals who have serious problems which could be treated effectively and efficiently (such as obsessive-compulsive disorder), but the client is not in a formal crisis. If the insurance company won't approve treatment and the client can't afford to pay out of pocket, some wonder what providers will do.

The insurance company's solution might be for providers to refer such clients to the local community mental health center, but many of these sites have few staff members who have training in treating certain specific disorders, and as funding streams for community mental health centers shift, their ability to subsidize treatment is rapidly diminishing. This system creates an incentive for clients who want treatment to go into crisis, or for therapists who want to provide treatment to lie about the client's status.

This highlights the importance of understanding the plan you're participating in and being sure that participating is ethical and legal, not simply financially viable.

The financial motivation of the managed care insurers and the financial incentive to the primary-care "gatekeepers" sometimes undercuts and denies competent standards of practice provision of mental health services. A June 1996 article in the Arizona Republic by Steve Wilson maintains that anti-depressants are being overprescribed. Primary-care physicians, who have little or no psychiatric training, are delivering 65 percent of the psychiatric care in this country and doing it primarily with drugs. About 43 million prescriptions for anti-depressants were written in America in 1995. Sales of Prozac, Paxil and Zoloft were up 24, 35 and 45 percent, respectively, in 1995. Wilson voices concerns about the growing power of the drug companies over health care; drug companies are spending lavishly to advertise prescription drugs such as Serzone and Effexor directly to consumers, encouraging them to believe their pills can cure whatever is bothering them. According to a recent Rand Corporation study, primary care physicians prescribe anti-depressants to patients after an average of only three minutes of conversation.

Primary care physicians receive little if any training in psychotherapy and consequently rely heavily on medication management when confronted with psychological disorders. MCOs see this as very cost effective, as they can limit the cost outlay for psychotherapy by treating primarily with medications. Primary care physicians are cutting costs by prescribing the majority of psychotropic medications and refraining from making referrals to specialists, despite the fact that psychiatrists may be more familiar with the complexities of using some of the newer medications and conducting symptom-focused pharmacotherapy.

Referrals for counseling to masters level providers also have cost advantages, as these subdoctoral counselors

tend to adhere more to the cookbook guidelines established by the MCOs, and are reimbursed at a lower rate. One managed care case manager stated off the record that MA/MSW level providers "took direction better and didn't give us as much trouble". Several MCOs use paraprofessionals (BA or less) and nurses to do intake assessment, case management, and utilization review. It often takes an appeal for review of a refusal tc reimburse care on the grounds that it is "not medically necessary" before one gets access to a doctoral level professional. Although research has thusfar failed to establish the superiority of highly trained professionals in providing structured psychotherapy, some studies have found that professionals perform better when treatment must be brief.

The introduction of utilization review has prompted serious concerns about patient confidentiality. Since the earliest days of psychotherapy, confidentiality has been seen as one of the fundamentals of treatment, a prerequisite for giving patients the freedom to explore their innermost feelings and fantasies. Indeed, many therapists say, confidentiality is to therapy what a sterile field is to surgery -- a basic requirement of good practice. But even as the use of therapy is expanding, with more kinds of professionals seeing more patients, the confidentiality of psychotherapy is being eroded by a wide variety of outside forces, including the spread of managed care, the computerization of medical records, and the use of therapist's notes and records in law enforcement.

In justifying care, providers are exxpected to share increasing amounts of information about patients' symptoms, treatment goals, planned interventions, and patients' responses to care. As consolidation continues, and MCOs increase in size, enveloping smaller companies, the risk to confidentially is increased. Patients' records are placed in a computer data base where case managers and other administrative personnel working in the MCO are privy to unguarded information. Before managed care, such files were considered privileged information and they were more closely safeguarded; in outpatient cases therapists would often even challenge court orders attempting to access protected information. Now, outpatient therpaists are routinely expected to discuss cases over the phone with utilization reviewers. Therefore some feel that nature of the confidential therapeutic relationship has been dangerously uprooted by the advent of the MCO, with its use of utilization review.

Although many MCOs pride themselves in responding promptly to client calls, some practices may result in miscommunication which deters actual treatment. Some fault the current managed care intake interview process, because it subtly discourages clients from pursuing the treatment the clients initiate. Schwarz (1989) discovered that 60% of

the patients interviewed don't return for treatment through the managed care company, because they didn't expect to get treatment. Some didn't realize that the person conducting the intake interview was not the psychotherapist, and that the discussion was not meant to be a therapeutic session. When clients didn't feel like the session had helped, they quit. This is quite advantageous for the managed care company, but obviously a problem for consumers. Clearer communication with clients is obviously needed, but the managed care companies that profit from clients' ignorance are unlikely to initiate these improvements without some external prodding.

Potential Conflicts of Interest

Questions have been raised about the ethical and practical soundness of current managed care systems because they pursue contradictory goals. Although the goals of managed care purport to be in the best interest of the patient, often they conflict with the financial interests of the managed care organization (Rodwin, 1995). Managed care organizations have the following objectives: reduce expenditures and the use of services, increase efficiency, eliminate unnecessary and potentially harmful treatments, provide better or more desirable treatments for patients, expand the range of services offered, and improve patients' quality of life.

These objectives can jeopardize the integrity of the therapist's decisions, and cause divided loyalties because of competing obligations. For example, a case manager, in order to reduce expenditures and the use of services, may require a physician to use a less expensive and less effective treatment, that the physician knows may be detrimental to the patient's quality of life. Increased efficiency and provider productivity may cause the patient to receive less individual attention. Conversely, the reduction of medical costs will benefit the patients in that it will lower their premiums, and perhaps ultimately make health care more widely available.

Informed consent, which requires physicians to explain to patients the choices available, the risks and benefits of any proposed treatment, and any alternatives, is being compromised because providers do not inform patients of the their restricted clinical choices. Public policies need to be developed to mitigate these conflicts of interests.

The Downside of Managed Care for providers

Provider Objections to Managed Care

MANAGED CARE COMPANIES INTERFERE WITH THE DOCTOR-PATIENT RELATIONSHIP IN THAT THEY ATTEMPT TO AND SUCCEED IN DICTATING TREATMENT.

MANAGED CARE COMPANIES DEMAND SENSITIVE INFORMATION ABOUT PATIENTS IN GREAT DETAIL, WITHOUT STATUTORY OR ANY OTHER CREDIBLE ASSURANCES THAT CONFIDENTIALITY WILL BE PROTECTED.

MANAGED CARE COMPANIES ARE MAKING HUGE PROFITS, MADE OBSCENE BY THE FACT THAT THEY ARE DERIVED FROM MONEY BEING DIVERTED FROM PATIENT CARE.

MANAGED CARE COMPANIES HAVE REDUCED THE HEALING ARTS TO ACCOUNTING, WITH AN EMPHASIS NOT ON COST EFFECTIVENESS, BUT ON PROFIT.

MANAGED CARE COMPANIES HAVE CREATED A CLIMATE OF FEAR IN THE PROFESSIONAL COMMUNITY: FEAR OF ADVOCATING FOR THE CARE DOCTORS BELIEVE THEIR PATIENTS NEED.

ANNUAL RECREDENTIALING FEES AND RECREDENTIALING ASSESSMENTS ARE THINLY VEILED PROFIT-MAKING SCHEMES

CLINICAL JUDGMENT AND PATIENT CHOICE PRODUCE BETTER OUTCOMES THAN CASE MANAGEMENT

LONG TERM THERAPY WORKS MORE EFFECTIVELY FOR CERTAIN CONDITIONS AND IS WORTH THE COST

LICENSED AND EXPERIENECED DOCTORAL LEVEL PROVIDERS DO A BETTER JOB OF DIAGNOSIS AND THERAPY THAN RELATIVELY UNTRAINED MASTER'S LEVEL PROVIDERS.

For providers, the new increases in accountability for treatment outcome have been accompanied by reduced control over how they provide their patients treatment. The demand to be measurably efficacious is more threatening to providers who now feel they must surmount new hurdles to keep patients in treatment.

Mental health care professionals are experiencing frustration as their ability to dictate the necessary course of treatment for their patients is threatened by utilization reviewers who authorize services. These case managers assign patients to the least expensive appropriate treatment in the name of cost containment (Iglehart, 1996).

Managed behavioral care companies limit services by permitting patients to use only preferred panel providers who have been approved by the managed care organization (MCO). These providers consistently have their decisions reviewed and are monitored closely, especially in the treatment of chronic patients who pose a greater cost risk for the MCO. Mental health care providers thus feel their autonomy and incomes slipping away.

The Inefficiency of Outpatient Utilization Review (UR)

Psychotherapists have found the process of utilization review a cumbersome nuisance that frequently places them in an adversarial stance with the managed care company, feeling the need to fight for the opportunity to offer patients the treatment they require. Critics argue that outpatient utilization review can be a wasteful process that increases administrative costs dramatically. Since most outpatient cases tend to be brief anyway, the savings associated with close monitoring may be negligible, and more than offset by the costs of the utilization reviewers' salaries.

While utilization review has proven cost-effective with in-patient care, questions remain regarding its utility for out-patient care. Zach and Cohen (1993) maintain that utilization reviewers do not provide any added care, and may actually increase administrative expenses as much as 20%. A study in the New England Journal of Medicine concluded that the administrative costs of utilization review could consume as much as 50% of total health care spending by the year 2030 (Schilling, 1993) . Increasing assumption of utilization review responsibility by providers may remedy this inefficiency, if they can demonstrate an appropriate level of fiscal accountability.

Many analysts beliee that the real behavioral health savings lie in reducing inpatient care. Schilling (1993) states that seventy to eighty percent of all mental health dollars presently are spent on in-patient care, even though about 50% of hospitalized patients could be cared for as effectively in less costly outpatient settings. German (1994) concurs, reporting that approximately 70% of mental health dollars in the U.S. were spent on inpatient care, despite a decade of clinical research demonstrating that outpatient treatment and in-home care can be as effective as inpatient psychiatric treatment. Therefore, employers are turning increasingly toward managed care systems to reduce unnecessary hospitalization.

Excessive Administrative Overhead & Profit-taking

Craig Salins (1996) offers a very critical view of current trends in managed care. He argues that with the corporate realignments taking place in our health care system, managed care is not what it used to be. While managed care historically has meant efficient coordination of appropriate health care for the patient done in the consumer's best interest, in recent years insurance company profit-making has become the priority. The most successful MCOs are characterized by soaring profits for CEOs, and high stockholder satisfaction, which continues to provide the funding for the large-scale mergers that dominate the current health care delivery system. For example, a 1996 survey reported a 7.7 percent jump in median hospital CEO pay, which eclipsed the 2.7 percent pay hike received by the

average U.S. worker in the same period.

Despite their reputation for skyrocketing profits, recently there have been signs that some managed care companies are starting to experience less financial success. Some critics argue that this may be associated with the expansion of managed care to include subscribers from populations with higher rates of healthcare needs.

Some believe that in squeezing more profit from the health care dollar, many managed care companies have jeopardized the welfare of consumers. While coordinating and integrating the delivery of healthcare services to consumers, given the reality of limited resources, is widely seen as necessary, many oppose using 'managed care' as a means of denying needed benefits or services to clients in order to shift money to managerial and investor levels, under the guise of "cost control" and utilization management.

Managed care organizations' administrative overhead is seen by some as astronomical; estimates run as high as 55%. Furthermore, the creative accounting some companies use to calculate overhead can obscure actual allocation of resources. The insurance companies consider everything they pay to the MCO as going for "patient care" (Miller, 1995). In addition, Cunningham (1995) cites an example of an HMO placing utilization review in the category of "patient care expenses." This is in addition to all of the administrative work that is done by the provider (still classified by the MCO as costs devoted to "patient care"). The result is that figures exaggerate the expenditures on services that actually benefit consumers.

Providers criticize MCO decisions to deny or limit treatment to people who have paid for coverage. Some perceive the desire to please stock holders as having overrun concerns for quality care. The interests of the patient should not be subordinated to the interests of the corporation, yet some contend this disgrace is pervasive.

The elimination of access to effective treatment methods by arbitrary administrative cost-containment decisions, moving patients to the lowest cost providers without regard to the standards of care, and intrusions into the confidentiality of the psychotherapy relationship are serious problems cited by concerned providers. The pressure to move toward "capitation" contracts is also alarming to those who feel providers are unreasonably accepting increasing shares of the risk without commensurate advantages; they criticize state legislatures for permitting this to occur.

Seligman's Position

According to newly elected American Psychological Association president Martin Seligman, the survival of psychology as a profession and as a science is currently

being jeopardized by managed care. In his words, "As a profession, practitioners, particularly long-term therapists, are being forced out of the market by short-sighted health schemes, which often are run as much by greed as by concern for patient well-being. Those patients who need longer term treatment are routinely denied the full treatment they need and are routed to cheaper and briefer alternatives--which work much less well for them.

As a science, government funding and the availability of academic jobs are in drastic decline. Scientists at the top of the feeding chain are in trouble, and you can imagine how desperate things are for the new PhD. Amplifying these troubles is the fact that practice and science--natural allies -- don't get along at all well. Only when practice flourishes does science flourish, and only when science flourishes does practice flourish."

Individual Providers Complain About Managed Care

"I'm now in over 100 MC panels. They have made my professional life a nightmare of applications, dreadfully conceived credentialed forms, inane telephone and paper reviews, arbitrary authorizations and per hour income reduction. But what are my choices? I ignored MC for years and nearly went out of business. My income dropped 40% in just one year. I have seen very competent clinicians go under. If it were not for gaining admission to MC panels, I would now be out of business."

"Our clientele cannot and will not pay us privately. It seems to me that it is indeed a reality that if one wants to stay in practice, one must deal with managed care."

The frustration associated with overly restrictive treatment protocols of one established MCO provider is clear from the following statement: "A managed care organization has taken over management of the mental health benefits for a local HMO which accounts for perhaps 20% of our referrals. The new managed care organization has come up with some "interesting" treatment protocols. For example, their case managers tell us they are only allowed to authorize up to four sessions for the treatment of Major Depression, four sessions for Dysthymic Disorder, six sessions for Obsessive-Compulsive Disorder, etc. They don't simply mean that after this number of sessions we need re-authorization. They mean that this number of sessions should be all we need and that to get additional sessions we have to get a "medical review" by one of their psychiatrists and then maybe a few more sessions will be authorized.

We do state-of-the-art short term treatment, but obviously the time frames they have in mind are absurd. We immediately took this up with the executives at the MCO and they promise that the policy will be changed. If not, we'll

have to drop them too, because we don't feel we can ethically start treatment knowing that long before treatment is completed we'll face a choice between abandoning the client because they can't afford to pay out of pocket or accepting a fee lower than we can afford in order to allow the client to complete treatment. If we have to drop this plan, it will be a financial hardship, since they account for a significant portion (20%) of our referrals." This highlights the importance of not becoming too reliant on one HMO or MCO, because when their policies change, providers can be really stuck. It also illustrates the improtance of protesting blatantly problematic guidelines, because the company in question did revise their policy a few months after the complaints were made.

"A particular managed care company requires me to fill out a lengthy and intrusive form about the client and his/her personal and familial history with mental illness and prior counseling--which may or may not have anything to do with the presenting problem. In the past, I have told "customers" of this managed care company that if they wish to protest this procedure I will support them. (I usually fill out the required form and show it to them in advance. I try to keep the revelation of personal information to a minimum.) So far, no one has wished to protest this practice. My hypothesis, of course, is that clients feel helpless and/or reluctant to protest for fear of losing their coverage. But I do not pursue this directly in therapy because at that moment it seems to be more my issue than theirs. I feel reluctant to impose my agenda, even though it may involve a therapeutic issue for them. I focus more or less exclusively on the therapeutic issue without tying it directly to managed care or to their reluctance to object to managed care practices. Yet it is my perception that if these clients were emotionally healthy they would protest the practices. I think that some providers are handcuffed by their very ethical principles. They end up unable to assist clients in protesting managed care practices which are clearly unethical and not in clients' interests."

Managed care sometimes ends up benefitting from emotionally unhealthy attitudes of clients, in which they fear retaliation, rejection, and minimization of their emotional status. This seems to operate against mental health patients much more insidiously than physical health patients.

An MCO Insider's Frustrations

An anonymous disgruntled former managed care provider shared some insider experience which may be helpful to those deliberating about joining forces with managed care companies. "While some of my colleagues were competent therapists, others were not. In fact, the Peter Principle

was alive and well. In one instance, the utilization reviewer screamed down the hall in expletives about how stupid providers were because they kept asking for authorization to hospitalize clients. This reviewer had three answers for such requests: "No," "NO," and "Damn it, NO."

"In another instance, it was discovered that our office manager had been referring clients to her husband, a local marriage and family therapist, and that there had been no checks or balances to prevent this from happening. Case reviews were often embarrassing assaults on the abilities of the providers. The lack of professionalism was sad. There was only one way to do therapy, and providers were often not given further referrals if they called to consult on a case or ask for more visits. These attitudes were expressed by employees who had graduated from program supposedly providing them with systematic training in marriage and family therapy.

The treatment of in-house personnel was no better. We were expected to have over 30 bookable client-contact hours each week. That meant that if every slot was booked and everyone showed up, we could be expected to see over 30 families, complete hours of computer case notes, manage outside cases, act systemically to connect with other community resources, etc."

Some providers are giving up

One disgruntled providers chose finally to abandon managed care. "I no longer see m/c cases as I feel that the oversight is far too destructive to the therapist/patient relationship to permit psychotherapy to occur on any meaningful level. And the breach of privacy and confidentiality is insurmountable."

Another "provider casualty" wrote: "I'm giving up, after losing the managed care fight. As a psychologist who has been in private practice for about 10 years, I realized last night that it was almost time to pay another estimated tax payment. I will have to liquidate some of the resources that I thought I would live on when I retire.

I think I am a good therapist. I have built a practice doing work that I am proud of. I read about how long term therapy was a thing of the past and thought, "so what?". I have done brief problem focused cognitive and behavioral therapy since the beginning."

Need for better research

At present, a cloud of uncertainty hangs over managed behavioral healthcare. The quality of care patients receive, treatment outcomes, and patient satisfaction have not been adequately addressed in most assessment studies of MCOs.

While cost containment and profitability have been toted time and again in studies, what mental health behavioral health care is based upon - the health and lives of the patients - have often appeared to be ignored. Cost savings obtained at the expense of quality becomes a liability, not an asset.

Iglehart (1996) points out that so much change has taken place recently in the treatment of mental disorders and substance abuse because of the growth of for-profit companies that provide managed behavioral health care, that we have outstripped our ability to collect comprehensive data upon which to base our decisions. The relationship between mental health care providers and managed health care organizations has developed uneasily in this climate of uncertainty, rumor, and innuendo.

Iglehart's report states that there has traditionally been less coverage for mental health and substance abuse in private insurance because of the uncertainties often associated with their diagnosis and treatment. Also private insurance companies have traditionally preferred inpatient care, which led providers in the same direction.

The role of managed care is to control costs by limiting the use of services. This causes special concern that there may not be enough coverage for the severely and persistently mentally ill. The emergence of managed behavioral health care is seen in part as a reaction to abuses in private psychiatric hospitals. MBHC organizations operate by using reviewers to authorize services, and they often place providers in some degree of financial risk. The performance of these groups is controversial with providers, because it often directly interferes with treatment decisions. They have grown rapidly, however, because payors are satisfied with them because they reduce costs.

Currently, MBHC organizations are primarily measured by how well they reduce costs and on process related measures, such as how quickly they answer patients' calls. There is a growing awareness of the shortage of information about their impact on the availability of care or on the outcomes of patients. The proliferation of managed care has been so rapid and recent that existing research has been primitive, generally only examining basic variables such as utilization patterns, consumer satisfaction, and quantity of care. Staunch critics complain that the quality of care is jeopardized when treatment is forced to conform to the parameters of managed care. However, given the absence of empirical research, these objections are based largely on conjecture.

Most conclude that MBHC has realized significant cost savings and that it has also had a significant impact on the role of providers, however there is little information about patient outcomes. Iglehart (1996) and others have expressed concerns about the possibility that MBHC may stifle

development of new drugs and treatments and that the chronically mentally ill will not be well enough provided for. David Mechanic et al. (1995) researched and assessed the management of mental health and substance abuse services, and described the state of the art. Many fear that managed care is being applied to the treatment of mental illness and substance abuse in ways that are not sensitive to the special characteristics that distinguish these conditions from other health needs. It is easy to find anecdotal examples of both outstanding and distressing managed care practices. This makes it difficult to assess with any certainty the general consequences of managed care.

Many professionals believe that a broader array of outcome measures must be used, including ones that take into account the burdens of untreated mental illness on families and neighborhoods (including the physical and mental health of caregivers and the social costs of community living for people with mental illness). Only a comprehensive evaluation of the manner in which
managed care affects outcomes will permit confident assessment of its potential for achieving efficiency while protecting or enhancing quality. To prevent expansion of practices that compromise quality of care, many individuals advocate more independent studies, including those undertaken by a watch-dog group, as opposed to mental health care providers and MCOs.
Better research is sorely needed to develop a more complete picture of managed care effects and its success in actualizing its potential for achieving efficiency while enhancing the quality of service delivery.

Protests and Reforms

Strong efforts are underway to change perceived abuses of both patients and clinicians. Organized efforts in Michigan and other states are attempting to address these problems. Since 1993, a group of Michigan providers has worked with employer groups, labor, insurance companies, HMOs, etc. to preserve the right of subscribers to see the clinician of their choice, and the independence of providers to make clinical decisions. The Michigan group has defeated the efforts of managed care companies to develop provider panels exclusively featuring Master's level therapists, and they continue to work to make changes that truly benefit the subscriber, not just the clinician.

Given the capitalistic model that shapes the way we conduct business in this country, we should realize that third-party payees always restricted funding for mental health care, even before formal "managed care" came to be. It is important to keep in mind that insurance companies are businesses. They pay for services that people use as part of their health care benefit. They try to do it in a way

that yields a profit. In the long run, competition is good, because it provides for checks and balances, and allows the consumer, in our case the subscriber, to receive a good product at a good price. It is our task as providers to make sure the subscriber will still be able to use our services in the future.

For years many providers have been committed to a number of principals: fighting on behalf of anyone who seeks our services, not acquiescing to any demands which violate the privacy of our clients, and not continuing to work with insurance or managed care companies which deny an individual the right to choose their own therapist or restrict the clinical decisions by the treating clinician. Generally, such providers have been successful because they provide high level clinical services and are well known by the employer groups which hire these managed care companies to handle the mental health benefit. By taking these positions, and making them clear, employer groups have insisted on changes in policy by the managed care companies, protecting the freedom of choice by the subscriber, and the clinical autonomy of the clinician.

Beneficial changes are coming about as a result of providers' challenging managed care practices in their communities. In Michigan, for example, Options, which got the contract for State of Michigan employees, has now started a new program called "CareFirst", in which they will no longer micro-manage the outpatient benefit, but rather will simply grant the whole benefit up front at the start of treatment. They have eliminated the need to seek re-authorization for further sessions, etc. This seems to have come about because of many clinicians speaking out against the previous model, as well as their own internal realization that it was a ridiculous waste of money to micro-manage the benefit.

The way psychotherapists will have continued relevance and impact will be by delivering good clinical services, demonstrating that within our communities, being known to the business community where the decisions get made regarding the health care benefits for their employees, and bringing about reforms in managed care that reestablish the rights of the subscriber/client and the professional autonomy of the clinician.

In addition, courts and legislatures have grown increasingly uncomfortable with managed care organizations' focusing on their own financial health over patient well-being. One of the most outspoken, public opponents of managed behavioral healthcare is Karen Shore, Ph.D., who heads the National Coalition of Mental Health Professionals and Consumers. Several newspapers, magazines, and television programs have been running stories highly critical of various managed care policies. The public is becoming increasingly aware of the potential pitfalls of managed

behavioral healthcare, and has started to support a variety of reforms. Tomorrow's psychotherapists will need to keep abreast expected changes that hopefully will help to promote the evolution of a more balanced way of allocating resources for consumers' mental health needs. New clinicians have an important role to play in helping the nation to develop more conscientious means of assuring efficient, accountable delivery of psychotherapy.

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